Co-Occurring Joint Action Council

COMPENDIUM OF HOUSING MODELS THAT MEET THE NEEDS OF PERSONS WITH COD (November 25, 2008)

Introduction

Strategy 5.2 of California's Action Plan for Co-Occurring Disorders (COD) calls for the development of a compendium of housing models that meet the needs of persons with COD. This draft document reflects the work of the Housing Committee of the Co-Occurring Disorders Joint Action Council (COJAC). There is a growing recognition of the importance of housing among consumers, providers, state and local government officials, and other stakeholders from multiple sectors, including sectors that are primarily focused on mental health, substance abuse, homelessness, health care, criminal justice, child welfare, housing and community development. The purpose of this compendium is to create a common language and a framework that can be used across all of these sectors for considering a range of approaches to meeting the housing needs of persons with co-occurring disorders and their families, regardless of the sector responsible for enacting and implementing policy and funding.

Committee members have identified a range of permanent and transitional housing models that can be effective for people with COD. Some of these models may be more or less effective for some target populations than others. In making choices about where to invest resources to expand the availability of housing for people with COD, policymakers and other stakeholders will want to consider which models are designed to meet the needs of which target population(s), the outcomes that can be expected, and other issues that have been identified. In determining the most appropriate housing model or housing options to meet the needs of people with COD, program quality is critically important, and the qualities of staff and their relationships with tenants and consumers will have a significant impact on outcomes.

Principles

1. Recovery from mental health and substance use disorders is supported by safe and stable housing.
2. In most communities a range of options will be most responsive to the needs, culture and preferences of consumers.
3. Consumers benefit from having choice among a range of housing options, and having options available that are best suited to their needs and preferences.
4. Housing and service models for people with co-occurring disorders should support and provide opportunities for recovery, resiliency, and community integration.
5. Services linked to housing should be flexible and trauma-informed.
6. Housing and service models for people with COD should anticipate relapse and support individuals and families to maintain housing stability and/or find more appropriate housing options, while avoiding homelessness, when relapse occurs.
7. Investments of public resources should be guided by available research evidence regarding the effectiveness of housing models for people with COD.
8. All housing should be safe and quality should be consistent with applicable standards and criteria.
9. All transitional housing should provide linkages to permanent housing opportunities.
10. All permanent housing should be subject to the legal protections of landlord-tenant law.
11. Mandatory services may be more appropriate in transitional housing programs where tenants are expected to make progress toward achievement of identified goals, but less appropriate in permanent housing.
12. Where participation in services is a condition of tenancy, procedural safeguards and oversight of quality by an appropriate government agency must be in place. Depending on the scope of services and/or level of disability among tenants, programs with mandatory services may be subject to licensing requirements.
13. Some housing options may require a commitment to sobriety and/or other program rules. Consumers with COD should have meaningful choices about whether to accept these conditions or seek other housing options.
14. Housing for people with COD should be integrated into neighborhoods and communities and serve as a community resource.
15. The most successful and effective housing programs offer tenants opportunities for significant participation in leadership, governance, and participation in the development of community norms.

PROGRAM MODEL - PERMANENT	**DEFINITION & IMPORTANT CHARACTERISTICS**	**FOCUS POPULATION(S)**	**DOCUMENTED OUTCOMES**	**ISSUES (e.g. licensing, quality, other concerns)**	**RESOURCES For more information**
Permanent Supportive Housing consistent with definitions and quality criteria established by the Corporation for Supportive Housing and fidelity model for permanent supportive housing currently under development by SAMHSA CMHS. Including "low demand" or "Housing First" approaches	Housing is permanent & affordable (tenants pay 30-50% of income for rent). Range of settings including apartment buildings, scattered site apts., SRO's Services are flexible and participation is voluntary (NOT a condition of tenancy) Primary focus of services is housing stability & other goals (recovery) set by tenant. Tenant holds lease and normal responsibilities of tenancy. Particularly in "Housing First" models, no requirements / expectation that tenants will achieve sobriety or engagement in mental health treatment before moving into housing. Housing is provided first, and services are made available / connected to housing. Response to relapse = intensify service engagement & motivational enhancement efforts; eviction only for lease violations (not use per se).	All 4 quadrants COD. People who are homeless or at risk of homelessness and unable to get and/or keep housing without supportive services. Priority populations: o Chronically homeless people with disabilities o Transition aged youth o People re-entering community from criminal justice systems o Homeless families with disabilities and/or involved in family reunification	Housing stability: 80% or more maintain housing for at least 12 months Reductions in hospital emergency room and inpatient services use (50% +/-) Reductions in use of crisis services for MH or AOD problems (e.g. psych emergency / inpatient, detox, etc) Increased employment Family reunification	Federal and/or local housing quality standards apply. Subject to landlord-tenant law. Hard to fund services for tenant populations who are not eligible for MHSA "full service partnerships" and especially difficult for both "serial inebriates" if not seriously mentally ill and other people without serious mental illnesses (quadrants 1 and 3). Federal homeless program funding available for housing costs of new projects serving chronically homeless adults with disabilities (often COD), but federal funding for service costs in these projects is very limited or unavailable. Scattered site programs may create burdens to neighbors and/or community if adequate services are not available. Staff in these programs often serve people with severe COD but may not be integrated into ongoing training opportunities available to staff in MH & AOD treatment systems. Current state law makes supportive housing exempt from licensing under specific circumstances. Depending on the federal program funding the housing, HUD drug-free housing and one-strike rules ***may*** require (or allow) housing providers to deny housing or evict persons with current or past drug use in housing or drug-related criminal activity.	www.csh.org

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Permanent Supportive Housing (PSH) **–– with conditions** "High demand" program models implemented by some providers in CA and other states	Same as above BUT with <u>some or all of the following modifications:</u> Sobriety and/or commitment to recovery from addiction and/or involvement in mental health services may be required before person becomes eligible for housing. Participation in some supportive services may be required as a condition of tenancy and/or eligibility for ongoing housing subsidy "Clean & sober" supportive housing projects incorporate strong culture of sobriety as condition for entry and maintaining housing. Response to relapse = intensify service engagement efforts and linkages to substance abuse treatment; eviction if use continues.	Some of the same target population(s) as in other supportive housing . More likely to meet the needs and preferences of individuals who are seeking treatment or ongoing support after a period of treatment for substance use problems, and those who need to maintain sobriety as condition imposed by criminal justice or child welfare systems. High level of structure may work for a minority of chronically homeless individuals with COD but not for majority. May be effective for those in quadrant 1, 2 or 3 with high level of commitment to sobriety and willingness to comply with program rules. May not be accessible to those with COD in quadrant 4 (those with more severe mental disorder and more severe substance use disorder) who are not engaged in treatment outside crisis settings.	Housing stability rates somewhat lower than PSH with voluntary services (approx 60% of tenants remain for 1 year or more) Increased employment Family reunification	Requirements for participation in services as a condition of tenancy or housing assistance are not consistent with SAMHSA fidelity model under development. Service participation requirements as a condition of tenancy are not consistent with preferences of most consumers. . Service participation requirements and restrictions on private use of alcohol may be hard to enforce under local landlord-tenant law. Veterans Administration supportive housing program for homeless veterans (HUD VASH) requires participation in case management services as a condition of housing assistance. In some parts of the state Shelter + Care programs use this modified supportive housing model and require that each tenant participate in supportive services as a condition of eligibility for tenancy or rent subsidy. Depending on the federal program funding the housing, HUD drug-free housing and one-strike rules ***may*** require (or allow) housing providers to deny housing or evict persons with current or past drug use in housing or drug-related criminal activity. Services should be consistent with SAMHSA IDDT fidelity model.	

PROGRAM MODEL – Usually transitional	**DEFINITION & IMPORTANT CHARACTERISTICS**	**FOCUS POPULATION(S)**	**DOCUMENTED OUTCOMES**	**ISSUES (e.g. licensing, quality, other concerns)**	**RESOURCES For more information**
Sober Living Environments (SLE)	Houses or apartments shared by individuals committed to sobriety; housing is usually rented but may be a private owner who sponsors the project and rents to members of sober living household. Tenant-run; peer support among graduates of substance abuse treatment Generally no paid staff and no public funding Response to relapse = tenant expected to move out. Sobriety agreements may be part of tenant agreements but these practices may not be recognized or enforceable under local landlord-tenant law.	Usually single adults with a commitment to sobriety at time of move-in. Appropriateness of SLE for people with COD depends on **program quality** and the availability and effective linkages to other treatment and recovery support services. Most effective for those in either quadrant 1 or 3 (those with less severe mental disorders) with high level of commitment to sobriety and those who are engaged in other treatment and supportive services. High quality SLEs may be appropriate or effective for people with COD who have more severe mental disorders if they are engaged in other treatment services which provide adequate support . SLE's may not be appropriate for people with COD who are unable to make or sustain a commitment to sobriety.	COJAC Housing committee has not found evidence of documented outcomes for this model. It was reported that some outcomes have been reported in research and that researchers are working now to quantify outcomes but additional information was not provided.	No oversight by any public agency in most counties; some counties may provide oversight tied to funding. Rents unsubsidized – costs may be very high and/or bedrooms shared. Quality varies immensely: Significant concerns have been raised about quality and fidelity to "sober living model" in some communities. CAARR has developed minimum standards. Los Angeles County Sober Living Coalition has been working with patients' rights organization to establish quality standards and safeguards. Problems can arise when people with COD are inappropriately referred to SLE when other housing models would be a better fit for their needs and preferences but they are unavailable.	www.caarr.org

PROGRAM MODEL - TRANSITIONAL	**DEFINITION & IMPORTANT CHARACTERISTICS**	**TARGET POPULATION(S)**	**DOCUMENTED OUTCOMES**	**ISSUES (e.g. licensing, quality, other concerns)**	**RESOURCES For more information**
Transitional Housing – special needs models	Housing created as "aftercare" to support clean & sober living environment for graduates of residential treatment programs. Range of housing settings including shared apartments, dorms, or single family homes. Congregate housing is often reported to be preferable model. Time limits usually 9-12 months; in some counties residents sign leases or program participation agreements; in some programs there is no lease. Some "transition-in-place" models involve transitional supportive services and/or short term rent subsidies in a housing unit (e.g. privately owned apartment) where the tenant can continue living (with a lease) after program participation ends. Primary focus of services is maintaining sobriety / recovery and support for community re-integration (e.g. employment, family reunification, progression to permanent housing, etc.). Response to relapse = tenant expected to move out or must participate in treatment intervention .	Graduates of treatment programs who are committed to sobriety and need ongoing support for a time-limited transition period. ➢ Particularly important for women completing treatment and needing support and a place to live during family reunification. Some programs operate as "step down" from higher levels of care for acute mental health and/or AOD crises (e.g. following inpatient hospitalization). May be alternative to hospitalization and/or diversion from jail for person with COD who is homeless or in unstable housing.	Note: There is limited research available regarding transitional housing outcomes for people with COD. COJAC housing committee members have been invited to share information about outcomes from evaluations of transitional housing programs.	Time limits or other criteria for placement in transitional programs may require people to move if their needs and/or diagnoses change or when they reach a time limit. If appropriate, affordable housing is not available, tenants with most substantial disabilities (e.g. quadrant 2 or 4) and/or barriers to employment may experience homelessness or ongoing housing instability.	

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Transitional Housing – models developed for homeless adults and/or families	Similar to transitional housing special needs models described above, BUT: Services may focus more on assisting residents to obtain permanent housing and skills needed for maintaining housing and financial stability, employment, parenting. Range of housing settings including apartments, or shared single family homes. Often service participation and/or participation in activities specified in a service plan (e.g. employment search or training; housing search) is a requirement of residency. Time limits usually 18-24 months; usually there is a lease or program participation agreement. Some "transition-in-place" models (see above) allow tenants to remain in housing without moving after program participation ends. Usually prohibit use of alcohol or other drugs. Response to substance use = tenant expected to move out or must participate in treatment intervention.	Most frequently designed for homeless families and/or transition aged youth who are homeless or at risk of homelessness (e.g. when they leave foster care). May have limited capacity to serve people with more serious COD; maybe more appropriate for quadrant 1 (less severe mental disorder and less severe substance use disorder). Most appropriate for those who want to complete goals and move on to other forms of housing, especially if COD or other problems can be resolved or stabilized within 12-24 months.	Programs have a responsibility to ensure that residents exit transitional housing to permanent housing. 60 - 70 % of households leaving transitional housing moved directly to permanent housing (half of these without long term rent subsidies). Those who complete transitional housing are more than twice as likely to go to permanent housing as those who leave early. Increased employment (National data from HUD and other studies)	See above about time limits. Due to limited affordable housing in most communities, persons may not be able to transition to permanent housing, meeting the goal of this program. Possible difficulties with *retention rate* once moved into permanent housing, due to lack of skills or peer support.	

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Affordable Housing – service-enriched affordable housing includes service coordinator(s) and/or other resident services	Usually housing developed and operated by non-profit owners or public housing authorities, or privately owned housing with rent subsidies that allow tenants to pay approximately 30% (no more than 50%) of their income for rent. Includes housing for families, seniors, people with disabilities, and other target populations. Some housing developments serve mixed income or mixed tenant populations. Some housing units may be set aside for people with COD, homeless, or other special needs. Service coordinators assess tenant needs and provide linkages to community services and other resources. Other typical services include child care; employment supports; computer lab; social and recreational activities; linkages to community services, and other resources. Services are not specifically focused on MH or AOD problems – OR services with this focus are provided through outreach or linkage in locations where many active or potential consumers live.	Target population is usually defined by income (e.g. for those with incomes under 30% of AMI) – not disability. In some locations or programs, there may be a priority for homeless individuals and families and/or people with disabilities. Appropriate for any person or family who has successfully used treatment services and supports to stabilize COD problems or who has established linkages to ongoing community supports.	Vast majority of homeless families who receive a housing subsidy do not return to homelessness – even if they have MH and/or AOD problems	Shortage of appropriate, affordable housing may leave some people with COD facing a choice between living in settings that offer more supportive services (and restrictions) than they need, OR living in bad places that undermine their recovery. Federal law gives local public housing authorities substantial discretion to exclude or evict households in which a family member has a history of drug-related activity. These one-strike rules create barriers to housing for some people with COD.	www.nlihc.org www.aasc.org